



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 415 377-0544. If you have any questions about my Notice of Privacy Practices, please contact me at: P.O. Box 460732 San Francisco, CA 94146-0732; at [cal@calthera.org](mailto:cal@calthera.org); or at 415 377-0544.

I acknowledge receipt of the Notice of Privacy Practices of Cal J. Domingue, MFT.

Signature: \_\_\_\_\_

Name (please print): \_\_\_\_\_  
(patient/parent/conservator/guardian)

Date: \_\_\_\_\_

**INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including [describe good faith attempts]. However, because of

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I was unable to obtain my patient's acknowledgement.

Signature of Provider: \_\_\_\_\_

Date: \_\_\_\_\_